FY12-FY14

Maternal, Infant and Early Childhood Home Visiting: Request for Proposal

INDIANA STATE DEPARTMENT OF HEALTH

Division of Maternal and Child Health

APPLICATION DUE DATE
Friday, June 29, 2012
5:00 PM EST

Please use this document to complete the ***MIECHV: RFP APPLICATION***

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FUNDING OPPORTUNITY DESCRIPTION

PURPOSE

The purpose of this Request for Proposal (RFP) is to fund competitive grants for nonprofit organizations, local health departments, and health care entities within the State of Indiana for the implementation or expansion of evidence-based home visiting programs. These programs must focus on improving health and development outcomes for at-risk Indiana children and families in the following areas: maternal and infant health; child development and school readiness; family economic self-sufficiency; coordination with and referrals to other community resources; number of Emergency Department visits; and child maltreatment.

SUBMISSION INFORMATION

To be considered for funding, applications must be received by the Indiana State Department of Health (ISDH) no later than **Friday, June 29, 2012 at 5:00 PM EST.**

Applicants are **required** to submit applications electronically. For electronic submission:

> SUBMIT APPLICATIONS VIA EMAIL TO ELINOR HANSOTTE, HOME VISITING PROGRAM COORDINATOR, AT: **EHansotte@isdh.IN.gov**
>
> MAIL ALL SUPPLEMENTAL MATERIALS THAT ARE UNABLE TO BE SENT VIA EMAIL TO:
>
> Indiana State Department of Health
> Division of Maternal and Child Health
> c/o Elinor Hansotte, Home Visiting Program Coordinator, 7C
> 2 N. Meridian St.
> Indianapolis, IN 46204
>
> *To ensure that the mailed supplemental materials are matched to each applicant's application, please write on the outside of the envelope the organization name, program name, and contact information. Please ensure that the supplemental materials are mailed in time to be received by ISDH no later than Friday, June 29, 2012.

LETTER OF INTENT

Those organizations planning to apply for Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding are strongly encouraged to submit a letter of intent to Holly Hilton-Dennis at HHiltondennis@isdh.in.gov no later than **5:00 PM EST on Friday, June 1, 2012.**

The letter of intent should provide a brief overview of the expected project. Note that applicants will not be held to the exact project proposed in a letter of intent. It is understood and expected that final project proposals will be refined and may vary slightly from the letter of intent.

The letter of intent must include the following:

- Project Title
- Agency Name
- Collaborating Partners
- Targeted Counties
- Brief description of the plan to achieve MIECHV Required Priority Areas
- Brief description of the target population
- Brief description of the evidence-based model

Letters of intent will be reviewed by ISDH's Maternal and Child Health (MCH) Division. Electronic feedback on partnerships, project ideas and performance measures may be provided by ISDH's Division of Maternal and Child Health to applicants who submit Letters of Intent, as deemed necessary.

DESCRIPTION OF FUNDING OPPORTUNITY

The ISDH MCH Division is requesting applications from local and statewide service providers and planning organizations (nonprofit entities, hospitals, schools, and local health departments) for competitive grant funding.

Funding will be used to implement and/or expand evidence-based home visiting programs. The following programs have been determined to be evidence-based by the United States Department of Health and Human Services: Early Head Start (Home-Based Option), Family Check Up, Healthy Families America, Healthy Steps, Home Instruction Program for Preschool Youngsters, Nurse-Family Partnership, and Parents as Teachers. **Please note: if the applicant agency is already receiving MIECHV funds, it is ineligible for this grant.**

BACKGROUND OF MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING FUNDING

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (ACA) of 2010. Through a provision authorizing the creation of the ACA Maternal, Infant and Early Childhood Home Visiting Program, the Act responds to the diverse needs of children and families in the communities at risk and provides an unprecedented opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The funds are intended to assure effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to these children and families through home visiting programs.

PRIORITY AREAS

As a requirement of the MIECHV Grant Application, ISDH performed a Statewide Needs Assessment in September 2010. This Needs Assessment was a condition of the receipt of funding to ensure that the Federal dollars were used to provide service to families residing in at-risk communities.

The Needs Assessment identified at-risk communities based on forty indicators linked to established home visiting outcomes. Some of these indicators included % Low Birth Weight, Rate of Infant Deaths, and % of Pregnant Women on WIC. The Needs Assessment identified 11 counties in the highest quartile; these 11 counties are targeted as the highest risk counties. The high-risk counties (or priority counties) in Indiana are the following: Marion, Lake, Scott, Elkhart, St. Joseph, Fayette, Jennings, Starke, LaPorte, Grant, and Owen.

The required priority elements of the MIECHV grant include: to support improvements in maternal, child, and family health; to support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected; to support the development of statewide or multi-state home visiting programs; to support the development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum; to reach high-risk and hard-to-engage populations; to support a family-centered approach to home visiting; to reach families in rural or frontier areas; and to support fiscal leveraging strategies to enhance program sustainability.

The MIECHV Grant Guidance also outlines client-specific priority areas. Priority should be given to serve eligible clients who: have low incomes; are pregnant women who have not attained age 21; have a history of child abuse or neglect or have had interactions with child welfare services; have a history of substance abuse or need substance abuse treatment; are users of tobacco in the home; have, or have children with, low student achievement; have children with developmental delays or disabilities; and/or are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

One requirement for reporting on the outcomes of the MIECHV grant was the creation of a Benchmark measurement document. Home visiting programs are required to have the ability to report on all outlined Benchmark measurements, at the stated time points. The six Benchmark areas are: improved maternal and newborn health; child injuries, child abuse, neglect, or maltreatment and reduction of Emergency Department visits; improvements in school readiness and achievement; crime or domestic violence (Indiana chose to report on domestic violence); family economic self-sufficiency; and coordination and referrals for other community resources and supports. Within each Benchmark area, there are between three and eight

constructs (or specific measurable areas relating to the Benchmark it falls under) for which data must be collected. The Benchmark measurements and collection time points are outlined in Descriptions of Required Priority Areas.

AWARD INFORMATION

SUMMARY OF FUNDING

Applicants should thoroughly describe the scope of the proposed project and justify the budget request for each category of allowable services for which they are applying, for a total of **no more than $200,000 per Fiscal Year**. Grant awards will be contingent upon Federal funding.

Applicants should clearly request funding for three (3) Fiscal Years in their grant application submissions. Funding for all approved budget periods beyond the first year of the grant is contingent upon the availability of funds, satisfactory progress of the project, and adequate stewardship of grant funds.

The anticipated start date for grants awarded under this announcement is **September 30, 2012**.

MCH is focused on building systems of care. Instead of funding isolated programs and services, MCH will only provide funds for organizations that collaborate and build integrated systems, especially those that enhance service capacity.

ELIGIBILITY & REQUIREMENTS

Applicant organization:

- Must be a non-profit organization (as defined by IRS Tax Determination), health department, hospital, or other health care related entity
- Must collaborate with traditional and nontraditional agencies or organizations
- Must serve populations within Indiana, specifically in one of the counties identified as high-risk (Marion, Lake, Scott, Elkhart, St. Joseph, Fayette, Jennings, Starke, LaPorte, Grant, and Owen)
- Must comply with contractual & financial requirements as listed in the Budget Section
- Must address all MIECHV Required Priority Areas
- Must implement or expand an evidence-based home visiting model. **Please note: if the applicant agency is already receiving MIECHV funds, it is ineligible for this grant.**
- Must distribute Sunny Start (a program which supports a coordinated system of resources and supports for young children from birth through age five and their families) educational materials which will be provided for free by MCH (http://www.in.gov/isdh/21190.htm)
- Must be able to collect specified Benchmark data at the specified time frame

EXPECTED REPORTING & PERFORMANCE CRITERIA

Applicants will be required to report quarterly and annually on specific performance criteria outlined in this RFP. Applicants will be required to participate in an annual site visit by State Home Visiting Program Coordinators and an outside evaluator. Applicants must also participate in a rigorous continuous quality improvement process, performed by the State Home Visiting Program Coordinators and an outside evaluator.

MIECHV: RFP APPLICATION

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SECTION 1: INSTRUCTIONS

Please use the **MIECHV: RFP Application** document for all required application information. The application, in its entirety including all supplemental information cannot exceed 50 pages with one-inch margins using an easily readable 12-point font. Applications that exceed the page limit will be considered non-responsive and will not be entered into the review process. The following outlines each Section that must be completed in the **MIECHV: RFP Application** document.

SECTION 2: COMPLETION CHECKLIST

The Completion Checklist in Section 2 serves as a guide to ensure that all appropriate and required materials are submitted with the **MIECHV: RFP APPLICATION** document. Double click on each check box to indicate a "check mark" for completion.

SECTION 3: IMPORTANT INFORMATION

In Section 3: Important Information, please list Name, Title, and signature of the following individuals within the applicant agency:

- Authorized Executive Official
- Project Director
- Person of Contact
- Person Authorized to make legal and contractual agreements

SECTION 4: SUMMARY

Section 4: Summary will provide the reviewer a succinct and clear overview of the proposed project. The summary should be the last section written and reflect the narrative. Please include a brief description of the project with the following:

- Briefly describe the purpose of the proposed project and the anticipated accomplishments (goals), including knowledge gained, and describe the measurable objectives to achieve the accomplishments. Please include how the project will achieve the goals of the priority areas.
- Briefly describe the target population (e.g., race, ethnicity, age, socioeconomic status, geography) and its needs and discuss why the specific interventions proposed are expected to have a substantial positive impact on the appropriate performance measure(s).

SECTION 5: APPLICATION NARRATIVE

In Section 5: Application Narrative, all required headings are listed with respective character limitations. Please do not alter the format of the document.

Applicants are strongly encouraged to discuss development of project-specific outcomes and performance measures with the Home Visiting Program Coordinators before submitting the application. Please see list of Home Visiting Program Coordinator contacts.

SECTION 5-1: ORGANIZATION BACKGROUND / CAPACITY (2000 CHARACTER LIMIT)

This section will enable the reviewers to gain a clear understanding of the applicant organization and its ability to carry out the proposed project—in collaboration with local partners.

- Discuss the history, capability, experiences, and major accomplishments of the applicant organization.
- Discuss the history, capability, experiences, and major accomplishments of the partnering organizations as they relates to the proposed project.

SECTION 5-2: EVIDENCE-BASED PROGRAMMING (2000 CHARACTER LIMIT)

Identify the evidence-based service(s) that will be expanded or implemented and discuss how the service(s) address(es) the purpose, goals and objectives of the proposed project. Please cite the sources of the information. **The following programs are deemed as evidence-based and will be the only services considered under this Request for Proposal.** These models must be implemented and/or expanded with fidelity to the national model. **Please note: if the applicant agency is already receiving MIECHV funds, it is ineligible for this grant.** For more information on evidence-based home visiting programs, please visit http://homvee.acf.hhs.gov/.

- Early Head Start (Home-Based Option)
- Family Check Up
- Healthy Families America
- Healthy Steps
- Home Instruction Program for Preschool Youngsters
- Nurse-Family Partnership
- Parents as Teachers

SECTION 5-3: NEEDS STATEMENT (4000 CHARACTER LIMIT)

This section must describe the nature of the problem(s) and the need for and significance of the project in the specific community or population as it relates to the priority areas. It is intended to help reviewers understand the need for the specific proposed strategies within the context of the community in which the strategies will be implemented. With respect to the primary purpose and goals of the grant program, please:

- Describe the population(s) of focus (demographic information on the population of focus, such as race, ethnicity, age, socioeconomic status, geography must be provided).
- Describe the geographic area(s) to be served.
- Use data to describe the needs and extent of the needs (e.g., current prevalence rates or incidence data) for the population(s) of focus.
- Provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.
- Please cite all references (do not include copies of sources).
- Describe how the needs were identified.
- Describe resources currently available to pregnant mothers and their children and identify gaps in service.
- Demonstrate how the applicant agency and its partner organization have linkages to the population(s) of focus and ties to grassroots/community-based organization that are rooted in the culture(s) and language(s) of the population(s) of focus.

Documentation of needs may come from a variety of reliable and valid sources including both qualitative and quantitative sources. Quantitative data can come from local epidemiologic data, State data (e.g., from State Needs Assessment), and/or National data.

SECTION 5-4: PROJECT GOALS AND OBJECTIVES (2000 CHARACTER LIMIT)

This section must describe how the program intends to achieve outlines MIECHV priority areas. It should clearly describe each priority area and objectives for achieving the priority area goals.

- Provide the overall project goal and each objective. Ensure the objectives are *S*pecific, *M*easurable, *A*chievable, *R*ealistic, and *T*ime-bound (SMART Objectives).
- Clearly state the unduplicated number of individuals the project proposes to serve (annually and over the entire project period) with grant funds.

- Describe how achievement of the goals will produce meaningful and relevant results (e.g., increase access to care, increase number of referrals to outside partners, increase number of clients with health insurance).

SECTION 5-5: ACTIVITIES (6000 CHARACTER LIMIT)

This section must describe the activities of the project. These must relate to the proposed objectives.

- Describe how the proposed evidence-based home visiting program will be implemented or expanded.

- Describe how the populations of interest will be identified, recruited and retained. Using knowledge of the language, beliefs, norms and values, and socioeconomic factors of the population(s) of focus, discuss how the proposed approach addresses these issues in outreaching, engaging, and delivering programs to this population (e.g., collaborating with community gatekeepers).

- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate the commitment of these entities to the project.

- Show that the necessary groundwork (e.g., planning, development of memoranda of agreement, identification of potential facilities) has been completed or is near completion so that the project can be implemented and service delivery begin as soon as possible and no later than four months after the grant award.

- Describe the potential barriers to success of the proposed project and how these barriers will be addressed.

- Describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.

SECTION 5-6: STAFFING PLAN (4000 CHARACTER LIMIT)

This section must describe the staff currently available and staff to be hired to conduct the project activities.

- List and describe the staff positions for the project (within the applicant agency and its partner organizations), including the Project Director and other key personnel, showing the role of each and their level of effort or full-time equivalency (FTE) and qualifications.

- Regardless of whether a position is filled or to be announced, please discuss how key staff have/will have experience working with the proposed population, appropriate qualifications to serve the population(s) of focus, and familiarity with cultures and languages of the proposed populations.

- Describe efforts to competitively compensate staff and plans for staff retention.

- Please be sure that the Staffing Plan matches the personnel listed in the Bio-Sketches and positions listed in Job Descriptions.

SECTION 5-7: RESOURCE PLAN / FACILITIES (2000 CHARACTER LIMIT)

This section must describe the facilities that will house the proposed services.

- Describe resources available (within the applicant agency and its partner organizations) for the proposed project (e.g., facilities, equipment).

- Assure that project facilities will be smoke, tobacco, alcohol, and drug-free at all times.

- Explain how the facilities and equipment are compliant with the Americans with Disabilities Act (ADA) and amenable to the population(s) of focus. If the ADA does not apply to applicant organization, explain why.

SECTION 5-8: EVALUATION PLAN (6000 CHARACTER LIMIT)

All applicants are required to collect data for reporting and monitoring purposes. This information must be collected on an on-going basis and reported quarterly and annually. In this section, the applicant organization must document its ability to collect and report on the required priority measurements.

Outcome Evaluation (for each of the bullets below, please list responsible staff and frequency)

- Describe plan for data collection. Specify all measures or instruments to be used; specifically, describe current collection efforts and plans to expand (as needed) to meet the MIECHV Benchmark measures.

- Describe plan for data management.

- Describe plan for data analysis.

- Describe plan for data reporting; specifically, describe current reporting efforts and plans to expand these efforts (as needed) to meet the MIECHV Benchmark measures.

- Describe methods to ensure continuous quality improvement, including consideration of disparate outcomes for different racial/ethnic groups (activities may include: chart audits, client surveys, observations).
- Describe the plan for maintenance of fidelity to the national evidence-based home visiting model.
- Describe plan for protection of client privacy, following HIPAA requirements.
- Describe plan of action if outcomes are not meeting or exceeding expectations during a quarterly or annual evaluation.
- Describe how MIECHV outcome data will be used to guide applicant's home visiting program in the future.
- Describe how outcomes will be disseminated to stakeholders within the applicant agency, its partnering agencies, and throughout local and statewide communities.

SECTION 5-9: SUSTAINABILITY PLAN (2000 CHARACTER LIMIT)

Outline a plan for how the program activities will be sustained at the conclusion of MIECHV funding. This may include, but is not limited to:

- Anticipated contributors of sustained funding (e.g., Medicaid, private funder)
- Plans to ensure dedicated staff after the conclusion of MIECHV funding
- Plans to continue collaborating partnerships

SECTION 5-10: LITERATURE CITATIONS (2000 CHARACTER LIMIT)

In this section, please list complete citations for all references cited, including (American Psychological Association [APA] style is recommended):

- Document title
- Author
- Agency
- Year
- Website (if applicable)

SECTION 6: BUDGET

The **MIECHV: RFP APPLICATION** document includes formats for each of the required attachments listed below. For budget-related questions, please contact Vanessa Daniels, MCH Grants Manager, at VDaniels@isdh.in.gov or (317) 233-1241.

SECTION 6-1: BUDGET REVENUE FY 2012
SECTION 6-2: BUDGET REVENUE FY 2013
SECTION 6-3: BUDGET REVENUE FY 2014

Please use the **MIECHV: RFP APPLICATION** document, Sections 6-1, 6-2, and 6-3, to fill out the required Budget Revenue information.

Sources of Anticipated Revenue

- List all anticipated revenue according to source. All revenue used to support the project operations must be budgeted.

SECTION 6-4: FY 2012 BUDGET NARRATIVE
SECTION 6-5: FY 2013 BUDGET NARRATIVE
SECTION 6-6: FY 2014 BUDGET NARRATIVE

Please use the **MIECHV: RFP APPLICATION** document, Sections 6-4, 6-5, and 6-6, to fill out the required Budget Narrative information for each Fiscal Year indicated.

The Budget Narrative must include a justification for every MIECHV line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the MIECHV budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement ($.44 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

- Round all amounts to the nearest dollar.

- Create a separate budget for Fiscal Year (FY) 2012, FY 2013, and FY 2014. FY 2012 runs September 30, 2012 through September 29, 2013. FY 2013 runs September 30, 2013 through September 29, 2014. FY 2014 runs September 30, 2014 through September 29, 2015.

Schedule A:

- For each individual staff, provide the name of the staff member and a brief description of their role in the project.
- If multiple staff are entered in one row (for instance, 111.400 Nurses) a single description may be provided if applicable.

- Each staff member must be listed by name. Calculations must be provided for each staff member in the Calculations column.
- This calculation should be in the form Salary = $/hr x hours/week x weeks/year.
- Fringe may be calculated for all staff. If different fringe rates are used for different categories of staff, Fringe may be calculated by category.

Schedule B:

- List each contract, each piece of equipment, general categories of supplies (office supplies, medical supplies, etc.), travel by staff member, and significant categories in Other Expenditures (such as Indirect) in the appropriate column. Provide calculations as appropriate.
- Calculations are optional for Contractual Services.
- Travel must be calculated for each staff member who will be reimbursed and may not exceed $0.44 per mile.

SCHEDULE A - CHART OF ACCOUNT CODES

111.000 PHYSICIANS

- Clinical Geneticist
- Family Practice Physician
- General Family Physician
- Genetic Fellow
- Medical Geneticist
- Neonatologist
- OB/GYN
- Other Physician
- Pediatrician
- Resident/Intern
- Substitutes/Temporaries
- Volunteers

111.150 DENTISTS/HYGIENISTS

- Dental Assistant
- Dental Hygienist
- Dentist
- Substitutes/Temporaries
- Volunteers

111.200 OTHER SERVICE PROVIDERS

- Audiologist
- Child Development Specialist
- Community Educator
- Community Health Worker
- Family Planning Counselor
- Genetic Counselor (M.S.)
- Health Educator/Teacher
- Occupational Therapist
- Outreach Worker
- Physical Therapist
- Physician Assistant
- Psychologist
- Psychometrist
- Speech Pathologist
- Substitutes/Temporaries
- Volunteers

111.350 CARE COORDINATION

- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Physician
- Registered Dietitian
- Registered Nurse
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitutes/Temporaries
- Volunteers

111.400 NURSES

- Clinic Coordinator
- Community Health Nurse
- Family Planning Nurse Practitioner
- Family Practice Nurse Practitioner
- Licensed Midwife
- Licensed Practical Nurse
- OB/GYN Nurse Practitioner
- Other Nurse
- Other Nurse Practitioner
- Pediatric Nurse Practitioner
- Registered Nurse
- School Nurse Practitioner
- Substitutes/Temporaries
- Volunteers

111.600 SOCIAL SERVICE PROVIDERS

- Caseworker
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Counselor
- Counselor (M.S.)
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitutes/Temporaries
- Volunteers

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitutes/Temporaries
Nutritionist (Master Degree)	Volunteers

111.800 MEDICAL/DENTAL/PROJECT DIRECTOR

Dental Director	Project Director
Medical Director	

111.825 PROJECT COORDINATOR

111.850 OTHER ADMINISTRATION

Accountant/Finance/Bookkeeper	Laboratory Technician
Administrator/General Manager	Maintenance/Housekeeping
Clinic Aide	Nurse Aide
Clinic Coordinator (Administration)	Other Administration
Communications Coordinator	Programmer/Systems Analyst
Data Entry Clerk	Secretary/Clerk/Medical Record
Evaluator	Substitutes/Temporaries
Genetic Associate/Assistant	Volunteers
Laboratory Assistant	

115.000 FRINGE BENEFITS

200.700 TRAVEL

Conference Registrations	Out-of-State Staff Travel
In-State Staff Travel	

200.800 RENTAL AND UTILITIES

Janitorial Services	Rental of Space
Other Rentals	Utilities
Rental of Equipment and Furniture	

200.850 COMMUNICATIONS

Postage (including UPS)	Reports
Printing Costs	Subscriptions
Publications	Telephone

200.900 OTHER EXPENDITURES

Insurance and Bonding	Insurance premiums for fire, theft, liability, fidelity bonds, etc. Malpractice insurance premiums cannot be paid with grant funds. However, matching and nonmatching funds can be used.
Maintenance and Repair	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
Other	Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project cost for the MIECHV grant:

1. Construction of buildings, building renovations;
2. Depreciation of existing buildings or equipment;
3. Contributions, gifts, donations;
4. Entertainment, food;
5. Automobile purchase;
6. Interest and other financial costs;
7. Costs for in-hospital patient care;
8. Fines and penalties;
9. Fees for health services;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Executive expenses (car rental, car phone, entertainment);
14. Client travel; and
15. Legislative lobbying.

The following may be claimed as project cost for MIECHV projects and may only be paid for with specific permission from the Director of MCH:

1. Equipment;
2. Out-of-state travel; and
3. Dues to societies, organizations, or federations.

All equipment costing $1,000 or more that is purchased with MIECHV funds shall remain the property of the State and shall not be sold or disposed of without written consent from the State.

For further clarification on allowable expenditures please contact: **Vanessa Daniels, MCH Grants Manager, at vdaniels@isdh.in.gov or 317-233-1241.**

SECTION 7: REQUIRED ATTACHMENTS

SECTION 7-1: BIO-SKETCHES (INSTRUCTIONS)

For positions already filled, provide a brief Bio-Sketch for five key personnel (note: there may be more than five positions, but please include only five Bio-Sketches).

SECTION 7-2: JOB DESCRIPTIONS (INSTRUCTIONS)

For positions to be announced and positions currently filled, please provide a brief Job Description for up to five key personnel (note: there may be more than five positions, but please include only five Job Descriptions).

SECTION 7-3: TIMELINE (INSTRUCTIONS)

Please include a minimum of the following information in the Timeline:

- List activities to occur within each of the Phases (Planning, Implementation, and Evaluation).
- Indicate in which quarter(s) each activity will occur.
- Please ensure these activities and dates of occurrence correspond with the activities and dates listed in the Activities narrative.

SECTION 8: ADDITIONAL REQUIRED DOCUMENTS

If applicable, please include the following required documents (no specific format required) with the **MIECHV: RFP APPLICATION** submission.

Please refer to the SUBMISSION INFORMATION section for more information.

SECTION 8-1: IRS NONPROFIT TAX DETERMINATION LETTER (1 PAGE MAX)

If applicable, please include with the submission of the **MIECHV: RFP Application** document, an attachment of an electronic copy (PDF recommended) of the applicant organization's IRS Nonprofit Tax Determination Letter. Please limit this attachment to 1 page total.

ATTACHMENT 8-2: ORG CHART & PROGRAM-SPECIFIC ORG CHART (2 PAGES MAX)

Please include with the submission of the **MIECHV: RFP Application** document, an attachment of an electronic copy (PDF recommended) of the applicant organization's overall organizational chart as well as the applicant organization's program-specific organization chart. The program

specific-organization chart must include program partners, existing program staff, to-be-hired program staff, key personnel, etc. Please limit this attachment to 2 pages total.

ATTACHMENT 8-3: LETTERS OF SUPPORT / AGREEMENT / MOUS (10 PAGES MAX)

Please include with the submission of the **MIECHV: RFP Application** document, an attachment of an electronic copy (PDF recommended) of letters of support, letters of agreement, and/or memoranda of understanding. These documents must include date, contact information of individual endorsing letter, and involvement with the project or organization. Please limit this attachment to 10 pages total.

DESCRIPTIONS OF REQUIRED PRIORITY AREAS

Priority Counties: Based on a Needs Assessment used to determine the counties in Indiana that are at highest risk, service provided under the Maternal, Infant and Early Childhood Home Visiting grant must be provided in one of the following eleven counties: Marion, Lake, Scott, Elkhart, St. Joseph, Fayette, Jennings, Starke, LaPorte, Grant, or Owen.

Priority Programs: The following programs have been deemed evidence-based by the Federal government. MIECHV funding must be used to fund one of the following programs: Early Head Start (Home-Based Option), Family Check Up, Healthy Families America, Healthy Steps, Home Instruction Program for Preschool Youngsters, Nurse-Family Partnership, or Parents as Teachers.

Priority Elements: To support improvements in maternal, child, and family health; to support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected; to support the development of statewide or multi-state home visiting programs; to support the development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum; to reach high-risk and hard-to-engage populations; to support a family-centered approach to home visiting; to reach families in rural or frontier areas; and to support fiscal leveraging strategies to enhance program sustainability.

Priority Client Enrollment: Priority should be given to serve eligible clients who: have low incomes; are pregnant women who have not attained age 21; have a history of child abuse or neglect or have had interactions with child welfare services; have a history of substance abuse or need substance abuse treatment; are users of tobacco in the home; have, or have children with, low student achievement; have children with developmental delays or disabilities; and are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Priority Measurements: Programs are required to be able to report quarterly and annually on each Benchmark item, at the stated time period. This means that programs must enroll prenatally and see clients through the child's second or third birthday. The Benchmark Plan Table is below. Each Benchmark is noted by a different color. Please note that the required measurement time frames are mentioned within the "Definition of Improvement." Note: In Benchmark 5 (please see benchmark plan table below), "income and benefits" are defined as earnings from work, plus other sources of cash support. These sources may be private, i.e., rent from tenants/borders, cash assistance from friends or relatives; sources may also be linked to

public systems, i.e., child support payments, TANF, Social Security (SSI/SSDI/OAI), and Unemployment Insurance. In-kind benefits include non-cash benefits such as nutrition assistance programs (e.g., SNAP and WIC), energy assistance, housing vouchers, etc., and could be estimated as the value of the benefit received. Educational attainment is defined as any participation in educational activities including, but not limited to: academic, vocational training, or certification programs. Please contact the Home Visiting Program Coordinators with any questions.

BENCHMARK PLAN TABLE

Benchmark 1: Improved Maternal and Newborn Health					
Construct	Performance Measure	Numerator	Denominator	Definition of Improvement	Population Assessed
1.1 Prenatal Care	Average number of weeks gestation when pregnant women begin to receive prenatal care	Number of weeks gestation when pregnant women begin to receive prenatal care	Number of women enrolled during pregnancy with target child	Decrease in average week of gestation when pregnant women begin to receive prenatal care, from those enrolled in Year 1 to those enrolled in Year 2.	Target women enrolled while pregnant with target child (Cohort)
1.2 Parental use of alcohol, tobacco, or illicit drugs	Percent of women who report quitting smoking during pregnancy by birth of target child	Number of women who report quitting smoking during pregnancy by birth of target child	Number of women who report smoking at initiation of pregnancy and are enrolled by 28 weeks gestation	Increase in percent of women who report quitting smoking during pregnancy by birth of target child, for individuals from intake (if enrolled by 28 weeks gestation) to birth of target children	Target women enrolled prenatally by 28 weeks gestation (Individual)
1.3 Preconception care	Percent of women with one or more well woman care visits (including 6-week postpartum visit)	Number of women who received well woman care (including 6-week postpartum visit) while not pregnant within 12 months postpartum	Number of women enrolled at 12 months postpartum	Increase in percent of women receiving well woman care (including 6-week postpartum visit) within 12 months postpartum of target child while not pregnant, from those enrolled in Year 1 to those enrolled in Year 2	Target women (Cohort)
1.4 Inter-birth intervals	Percent of women with subsequent pregnancies	Number of women with subsequent pregnancies within 12 months	Number of women enrolled at 12 months postpartum	Decrease in percent of women with subsequent pregnancies within 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target women (Cohort)

1.5 Screening for maternal depressive symptoms	Percent of women screened for maternal depressive symptoms	Number of women screened for maternal depressive symptoms within 6 months postpartum	Number of women enrolled for at least 6 months postpartum	Increase or maintenance in percent of women screened for maternal depressive symptoms within 6 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target women (Cohort)
1.6 Breastfeeding	Percent of women who initiate breastfeeding with their infant	Number of women enrolled before 28 weeks gestation who initiate breastfeeding with their infant	Number of women enrolled by 28 weeks gestation with target child who give birth to a live child while enrolled	Increase in percent of women who initiate breastfeeding with their infant as reported at the first postpartum home visit, from those enrolled in Year 1 to those enrolled in Year 2	Target women enrolled by 28 weeks gestation (Cohort)
1.7 Well-child visits	Average number of well-child visits per child	Number of well-child visits completed within 12 months postpartum of target child	Number of children enrolled at 12 months postpartum	Increase in average number of well-child visits per child within 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
1.8 Maternal and child health insurance status	Percent of women and children with health insurance	Number of clients with health insurance at 12 months postpartum	Number of clients enrolled at 12 months postpartum	Increase in percent of women and children with health insurance coverage at 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target women and children (Cohort)
Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits					
Construct	Performance Measure	Numerator	Denominator	Definition of Improvement	Population Assessed
2.1 Visits for children to the emergency department (ED) and/or Urgent Care from all causes	Rate of ED and/or Urgent Care visits per child from all causes	Number of ED and/or Urgent Care visits by children from birth (or enrollment if enrolled postpartum) to 12 months postpartum	Number of children enrolled at 12 months postpartum	Decrease in rate of ED and/or Urgent Care visits per child from birth (or enrollment if enrolled postpartum) to 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)

2.2 Visits of mothers to the emergency department from all causes	Rate of ED and/or Urgent Care visits per woman from all causes	Number of ED and/or Urgent Care visits by women from birth of target child (or enrollment if enrolled postpartum) to 12 months postpartum	Number of women enrolled at 12 months postpartum	Decrease in rate of ED and/or Urgent Care visits per woman from birth of target child (or enrollment if enrolled postpartum) to 12 months postpartum , from those enrolled in Year 1 to those enrolled in Year 2	Target women (Cohort)
2.3 Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome, poisonings, etc.	Percent of households that receive information or training on prevention of child injuries	Number of households that receive information or training on the prevention of child injury topics such as safe sleeping, shaken baby syndrome, poisoning, etc.	Number of households enrolled at 6 months postpartum	Increase or maintenance in percent of households receiving information or training on prevention of child injuries (according to the evidence-based curriculum of each program) by 6 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target households* (Cohort)
2.4 Incidence of child injuries requiring medical treatment	Percent of children with injuries requiring medical treatment	Number of children with injuries requiring medical treatment from birth (or enrollment if enrolled postpartum) to 12 months postpartum	Number of children enrolled at 12 months postpartum	Decrease in percent of children with injuries requiring medical treatment from birth (or enrollment if enrolled postpartum) to 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
2.5 Reported suspected maltreatment for children in the program (allegations that were screened; not necessarily substantiated)	Percent of children who received one or more suspected maltreatment reports through the Department of Child Services	Number of children with one or more suspected maltreatment reports through the Department of Child Services from birth (or enrollment if enrolled postpartum) to 12 months postpartum	Number of children enrolled at 12 months postpartum	Decrease in percent of children with one or more suspected maltreatment reports through the Department of Child Services from birth (or enrollment if enrolled postpartum) to 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)

2.6 Reported substantiated maltreatment (substantiated/indicated/ alternative response victim) for children in the program	Percent of children with one or more substantiated Department of Child Services maltreatment reports	Number of children with one or more substantiated Department of Child Services maltreatment reports from birth (or enrollment if enrolled postpartum) to 12 months postpartum	Number of children enrolled at 12 months postpartum	Decrease in percent of children with one or more substantiated Department of Child Services maltreatment reports from birth (or enrollment if enrolled postpartum) to 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
2.7 First-time victims of maltreatment for children in the program	Percent of children with a first-time substantiated Department of Child Services maltreatment report	Number of children with a first-time substantiated Department of Child Services maltreatment report from birth (or enrollment if enrolled postpartum) to 12 months postpartum	Number of children enrolled at 12 months postpartum	Decrease in percent of children with a first-time substantiated Department of Child Services maltreatment report from birth (or enrollment if enrolled postpartum) to 12 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
Benchmark 3: Improvements in School Readiness and Achievement					
Construct	Performance Measure	Numerator	Denominator	Definition of Improvement	Population Assessed
3.1 Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)	Percent of households with increased parental support for children's learning and development, as demonstrated through improved HOME Inventory subscale (Learning Materials and Involvement) scores	Number of households whose HOME Inventory subscale (Learning Materials and Involvement) scores improved from the infancy 6 month baseline to the toddler 18 month benchmark measure	Number of households enrolled at child's 6 and 18 months with completed HOME Inventory subscales (Learning Materials and Involvement)	Increase in HOME Inventory sub-scale (Learning Materials and Involvement) scores, for individuals from the baseline score at infancy 6 months to the benchmark score at toddler 18 months	Target households* (Individual)

3.2 Parent knowledge of child development and of their child's developmental progress	Percent of households that completed the *ASQ:3* and reviewed it with the home visitor	Number of households that completed the *ASQ:3* and reviewed it with the home visitor at infancy 12 months	Number of households enrolled at infancy 12 months	Increase or maintenance in percent of households that completed the *ASQ:*3 and reviewed it with the home visitor at infancy 12 months, from those enrolled in Year 1 to those enrolled in Year 2	Target households* (Cohort)
3.3 Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	Percent of households with increased positive parental behaviors and parent-child relationships, as demonstrated through improved HOME Inventory subscale (Responsivity and Acceptance) scores	Number of households whose HOME Inventory subscale (Responsivity and Acceptance) scores improved from the infancy 6 month baseline to the toddler 18 month benchmark measure	Number of households enrolled at child's 6 and 18 months with completed HOME Inventory subscales (Responsivity and Acceptance)	Increase in HOME Inventory sub-scale (Responsivity and Acceptance) scores, for individuals from the baseline score at infancy 6 months to the benchmark score at toddler 18 months	Target households* (Individual)
3.4 Parent emotional well-being or parenting stress	Percent of women screened for maternal depressive symptoms	Number of women screened for maternal depressive symptoms within 6 months postpartum	Number of women enrolled for at least 6 months postpartum	Increase or maintenance in percent of women screened for maternal depressive symptoms within 6 months postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target women (Cohort)
3.5 Child's communication, language and emergent literacy	Percent of children referred to outside services when child shows area of concern on *ASQ:3* (Communication subscale)	Number of children referred to outside services when child shows area of concern on *ASQ:3* (Communication subscale) at infancy 12 months	Number of children who show an area of concern on the *ASQ:3* (Communication subscale)	Increase or maintenance in percent of children referred to outside services when child shows area of concern on *ASQ:3* (Communication subscale) at infancy 12 months, as defined by *ASQ:3* as "below the cutoff," from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)

3.6 Child's general cognitive skills	Percent of children referred to outside services when child shows area of concern on *ASQ:3* (Problem Solving subscale)	Number of children referred to outside services when child shows area of concern on *ASQ:3* (Problem Solving subscale) at infancy 12 months	Number of children who show an area of concern on the *ASQ:3* (Problem Solving subscale)	Increase or maintenance in percent of children referred to outside services when child shows area of concern on *ASQ:3* (Problem Solving subscale) at infancy 12 months, as defined by *ASQ:3* as "below the cutoff," from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
3.7 Child's positive approaches to learning including attention	Percent of children referred to outside services when child shows area of concern on *ASQ:3* (Personal-Social subscale)	Number of children referred to outside services when child shows area of concern on *ASQ:3* (Personal-Social subscale) at infancy 12 months	Number of children who show an area of concern on the *ASQ:3* (Personal-Social subscale)	Increase or maintenance in percent of children referred to outside services when child shows area of concern on *ASQ:3* (Personal-Social subscale) at infancy 12 months, as defined by *ASQ:3* as "below the cutoff," from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
3.8 Child's social behavior, emotion regulation, and emotional well-being	Percent of children referred to outside services when child shows area of concern on *ASQ*-SE	Number of children referred to outside services when child shows area of concern on *ASQ*-SE at infancy 12 months	Number of children who show an area of concern on the *ASQ*-SE	Increase or maintenance in percent of children referred to outside services when child shows area of concern on *ASQ*-SE at infancy 12 months, defined by *ASQ* as "above the cutoff," from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
3.9 Child's physical health and development	Percent of children referred to outside services when child shows area of concern on *ASQ:3* (Gross Motor and/or Fine Motor subscales)	Number of children referred to outside services when child shows area of concern on *ASQ:3* (Gross Motor and/or Fine Motor subscales) at infancy 12 months	Number of children who show an area of concern on the *ASQ:3* (Gross Motor and/or Fine Motor subscales)	Increase or maintenance in percent of children referred to outside services when child shows area of concern on *ASQ:3* (Gross Motor and/or Fine Motor subscales) at infancy 12 months, defined by *ASQ:3* as "below the cutoff," from those enrolled in Year 1 to those enrolled in Year 2	Target children (Cohort)
Benchmark 4: Domestic Violence					
Construct	Performance Measure	Numerator	Denominator	Definition of Improvement	Population Assessed

4.1 Screening for domestic violence	Percent of women screened for domestic violence	Number of women screened for the presence of domestic violence at intake	Number of enrolled women with at least one home visit	Increase or maintenance in percent of women screened for domestic violence at intake, from those enrolled in Year 1 to those enrolled in Year 2	Target women (Cohort)
4.2 Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries)	Percent of women given referrals to relevant domestic violence services of those women identified for the presence of domestic violence	Number of women referred to outside, relevant, domestic violence services	Number of enrolled women identified for the presence of domestic violence at intake	Increase or maintenance in percent of women referred to domestic violence services of those women identified for the presence of domestic violence at intake, from those enrolled in Year 1 to those enrolled in Year 2	Target women identified for the presence of domestic violence (Cohort)
4.3 Of families identified for the presence of domestic violence, number of families for which a safety plan was completed	Percent of women for which a safety plan was created of those women identified for the presence of domestic violence	Number of women for which a safety plan was created of those women identified for the presence of domestic violence	Number of enrolled women identified for the presence domestic violence at intake	Increase or maintenance in percent of women for which safety plans were created of those women identified for the presence of domestic violence at intake, from those enrolled in Year 1 to those enrolled in Year 2	Target women identified for the presence of domestic violence (Cohort)
Benchmark 5: Family Economic Self-Sufficiency					
Construct	Performance Measure	Numerator	Denominator	Definition of Improvement	Population Assessed
5.1 Household income and benefits	Percent of households with an increase in income and benefits[+]	Number of households with an increase in income and benefits from month of enrollment to one-year post enrollment	Number of households enrolled for one year	Increase in income and benefits, for individual households from month of enrollment to one-year post enrollment	Target households* (Individual)

5.2 Education of adult members of the household	Percent of households with an increase in educational attainment[$]	Number of households with individual(s) with under 12 years of education with an increase in educational attainment from month of enrollment to one-year post enrollment	Number of households with individual(s) with under 12 years of education who are enrolled for one year	Increase in educational attainment, for individual households from month of enrollment to one-year post enrollment	Target households* (Individual)
5.3 Health insurance status	Percent of women and children with health insurance	Number of clients with health insurance at one-year post-enrollment	Number of clients enrolled for one year	Increase in percent of women and children with health insurance coverage, for individuals from month of enrollment (if mother is enrolled prenatally, enrollment is defined as birth for target child) to one-year post-enrollment	Target women and children (Individual)
Benchmark 6: Coordination and Referrals for Other Community Resources and Supports					
Construct	Performance Measure	Numerator	Denominator	Definition of Improvement	Population Assessed
6.1 Number of families identified for necessary services	Percent of households identified for need of additional services	Number of households identified for need of additional services at first home visit	Number of households with one home visit	Increase or maintenance in percent of households identified for additional services at first home visit, from those enrolled in Year 1 to those enrolled in Year 2	Target households* (Cohort)
6.2 Number of families that required services and received a referral to available community resources	Percent of households identified with a need who receive a referral to an available community resource	Number of households identified for need of additional services at first home visit who receive referral to an available community resource within 6 months post-enrollment	Number of households identified for need of additional services at first home visit	Increase or maintenance in percent of households identified with a need for additional services at first home visit who received a referral to an available community resource within 6 months post-enrollment from those enrolled in Year 1 to those enrolled in Year 2	Target households* (Cohort)

6.3 MOUs: Number of Memorandum of Understanding or other formal agreements with other social service agencies in the community	Number of formal agreements with other social service agencies	Number of MOU agreements or other formal agreements with other social service agencies in the community over last 12 months	-	Increase in number of formal agreements (as defined by signed agreement between a home visiting program/home visiting parent organization and an outside entity that describes the relationship between the two) with other social service agencies over last 12 months, from Year 1 to Year 3 data	Community agencies (Cross-sectional)
6.4 Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Number of agencies that engage in regular communication with the home visiting provider	Number of agencies that engage in regular communication with the home visiting provider over last 12 months	-	Increase or maintenance in number of agencies that engage in regular communication (as defined by communication/contact that occurs at least quarterly with regards to the home visiting program) with the home visiting provider over last 12 months, from Year 1 to Year 3 data	Community agencies (Cross-sectional)
6.5 Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided)	Percent of households with referrals for which receipt of services can be confirmed	Number of households given referrals to outside agencies within 6 months when identified for need of additional services at first home visit for which the receipt of services can be confirmed at one-year postpartum	Number of households given referrals to outside agencies within 6 months when identified for need of additional services at first home visit	Increase or maintenance in percent of households given referrals to outside agencies within 6 months when identified for need of additional services at first home visit for which receipt of services can be confirmed through client self-reporting at one-year postpartum, from those enrolled in Year 1 to those enrolled in Year 2	Target households* (Cohort)

ADDITIONAL RESOURCES

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